Mental Welfare Commission for Scotland

Report on announced visit to:
McNair Ward, Gartnavel Hospital, 1053 Great Western Road, Glasgow, G12 0YN

Date of visit: 25 September 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

McNair Ward is a 20-bedded unit in Gartnavel Hospital that provides acute mental health admission for individuals.

On the day of our visit, there were 20 people on the ward and no vacant beds.

We last visited this service in September 2024 on an announced visit and made no recommendations.

On the day of this visit, we wanted look at issues that have an impact on care and treatment, including the participation of individuals, families and/or carers.

Who we met with

We met with seven people, reviewed the care for five of these individuals and reviewed the care notes of one person that we did not meet with. No relatives wished to speak with us on the day of our visit.

We spoke with the service manager, the senior charge nurse (SCN), the lead nurse (LD), the consultant psychiatrist (CP), the patient activity coordinator (PAC), the physiotherapist and the occupational therapist (OT).

Commission visitors

Gemma Maguire, social work officer

Justin McNicholl, social work officer

Dr Rachael Lee, ST6 psychiatry of intellectual disability

What people told us and what we found

Individuals we met with told us staff were 'helpful' and 'lovely'. On the day of our visit, we observed that staff on McNair Ward were responsive, warm and caring with individuals, many of whom had complex needs.

We met with various members from the multidisciplinary team (MDT) and heard about good practice in relation to individualised care being provided. This included those with physical health conditions being supported by the MDT with activities such as hand massage, gym sessions and Tai Chi. Staff that we met with told us how the MDT work collaboratively and the culture on McNair Ward was 'friendly' and 'welcoming'.

We also heard from various people that staff shortages and/or increased demand on the service, particularly in relation to OT and nursing staff, can place additional pressure on the service. The SCN, the SM and the LN informed us that the demand in relation to providing continuous intervention (CI) for individuals regularly impacts clinical activity, including attendance at MDT meetings. CI can be a therapeutic intervention provided to individuals who are acutely unwell and require a higher level of staff observation to ensure their and/or others safety.

We were advised that managers are analysing CI data across NHS Greater Glasgow and Clyde (NHS GGC) and have identified variations in the number of CIs between acute adult admission services. We heard how this is a complex issue affected by various factors, including geographical catchment areas, specifically for those areas that experience higher levels of deprivation. We were also advised that some areas have higher student populations who may be more vulnerable to mental health difficulties.

We were pleased to hear NHS GGC are linking with local colleges and universities to address concerns around student mental health, particularly those living away from home.

The SCN and the LN shared that the lack of bed availability across NHS GGC services can impact on clinical activity. We heard how some individuals who have a learning disability are being cared for in McNair Ward due to no speciality beds being available elsewhere. We were advised that for these individuals, plans are progressing for transfer to specialist inpatient services, but often they have complex needs that require staff to provide higher levels of care and support.

We heard from the CP and the SCN that some individuals were delayed in their discharge from hospital, with social work assessments progressing, but at times it can be difficult to find suitable accommodation and/or support services.

We met with a psychologist who informed us that the service are encouraging staff to refer individuals to psychology services when they become subject to CI. We heard how this can provide access to psychological interventions at an earlier stage, as well as ensuring interventions are individualised to support recovery. We were informed that this is a new process, and referrals are not being consistently received. We discussed with the SCN and the LN on the day of our visit, who advised this was a valuable service for individuals and staff, and managers would ensure referrals are progressed timeously. We look forward to hearing how this progress on future visits to the service.

Care, treatment, support, and participation

Care records

All care records, including care plans, multidisciplinary team (MDT) records and risk assessments, were accessible on the electronic recording system, EMIS.

On our last visit to the service, we found care plans were meaningful, and person-centred. During this visit we found the language in some plans to be generic and at times repetitive. We noted that some plans had identical statements being used in relation to different people and were not individualised. We also found that some care plans lacked detail on what specific interventions were being used to support individuals to achieve identified goals.

Recommendation 1:
Managers responsible for McNair Ward should carry out an audit of person-centred care plans to ensure they are individualised with meaningful interventions clearly recorded.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

We found individuals had risk assessment documents in place with historical information. However, we noted that some documents had not been reviewed and/or updated timeously. We also found that risk assessment documents lacked detail on how staff can support individuals to manage risk to themselves and/or others.

Recommendation 2:
Managers responsible for McNair Ward should audit risk assessment documentation to ensure they are reviewed, with information provided on how each risk should be managed.

We noted that some care plans and/or risk assessment documents did not record the views of individuals' and/or their families. On the day of the visit, we provided

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

advice to the LN and the SCN to ensure that individuals and/or their families are consulted, with their views clearly recorded.

Recommendation 3:
Managers responsible for McNair Ward should audit all care records to ensure individuals and their families are being appropriately consulted with their views clearly recorded.

Multidisciplinary team (MDT)
The MDT for McNair Ward consists of nursing staff, a CP, an OT, a dietician, junior doctors, pharmacy, a PAC and psychology. At the time of our last visit to the service, we reported that MDT records related to person-centred care plans, with a clear record of actions and decisions being made.

During this visit we found some MDT records with clear actions, however this was not consistent. Some records lacked clear actions and/or follow up on actions which had been agreed at the previous meeting. Some staff we met with on the day of the visit told us that clinical demands have had an impact on staff's capacity to attend MDT meetings. While we understand the pressures faced by the service, we gave advice on alternative ways that staff can contribute to meetings, including written reports being given before a meeting and/or joining remotely.

Recommendation 4:
Managers in McNair Ward should audit MDT records to ensure discussions and agreed actions which relate to individualised care goals are consistently recorded and acted upon.

Use of mental health and incapacity legislation

On the day of the visit, 11 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All individuals detained under the Mental Health Act were aware of their rights. Several individuals had nominated a named person, were receiving legal advice and accessing advocacy services.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We found discrepancies with two certificates authorising treatment (T3s) under the Mental Health Act. One person did not have the prescribed medication authorised correctly and another person was prescribed regular medication which was only authorised to be given as required. The auditing process implemented by McNair

Ward had identified these issues and the SCN had escalated to the CP for action prior to our visit.

Recommendation 5:
Medical staff on McNair Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found the relevant documentation and that the named person had been appropriately consulted.

For people we met with and/or reviewed who were subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we did not find copies of welfare guardianship orders and/or power of attorney documents, as would be expected.

We discussed this with the SCN and the LN on the day of our visit and advised that copies should be obtained from guardians and/or attorneys to ensure staff are aware of powers that are in place for these individuals.

Recommendation 6:
Managers responsible for McNair Ward should ensure copies of guardianship orders, or power of attorney documents are available in individual care records.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

For some individuals where a section 47 certificate was required, we did not find a treatment plan on an Annex 5 form. This should be completed by the clinician with overall responsibility for the individual. The treatment plan should be written to include all the healthcare interventions that may be required during the time specified in the certificate.

The treatment plan should be clear on whether the individual has capacity to make decisions regarding nutrition, hygiene, skin care, vaccinations, eyesight, hearing, and oral hygiene.

Recommendation 7:
Medical staff should ensure that, where a treatment plan is required for a s47 certificate, it is completed for all patients.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

On the day of our visit, three people in McNair Ward were specified under the Mental Health Act. We reviewed the care records for these individuals and found that a reasoned opinion was recorded in relation to restrictions imposed. We found that all three individuals had not been notified in writing about the restrictions that were in place, or where there should be review timescales and their rights in relation to the measure(s) in place. We fed this information back to the SCN and the SM on the day of our visit for them to action.

Recommendation 8:
When someone is made a specified person, medical staff responsible for McNair Ward should provide individuals with written information regarding restrictions in place, timescales for review and information about their rights.

Managers should consider MDT training in the application and use of specified persons. The Commission has produced good practice guidance on specified persons[2].

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements.

We did not find any statements and/or evidence in care notes that these were being discussed with individuals. We were were informed that advance statements are discussed during one-to-one nursing sessions, reviewed in MDT meetings and can be supported by advocacy services. We would encourage managers to audit records to ensure advance statements are consistently promoted, with discussions recorded in individual care notes. We look forward to hearing about progress during future visits to the service.

Activity and occupation

At the time of our last visit to the service, we reported on the varied range of activities available to individuals, including access to a gym, art therapy and pet therapy.

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

We were pleased to find that these have continued to be provided with support from the OT and the PAC, as well as a volunteer coordinator. We also found that MDT assessments were in place to support individual recovery and discharge from hospital.

The physical environment

The ward was bright and spacious, with room for therapeutic activities, receiving visitors, a TV/lounge area and dining area.

Individuals could access two outdoor garden areas, which were well maintained. We were informed by some individuals we met with that one of the garden areas is kept locked and that they have to ask staff to open it. We discussed with SCN on the day of the visit who advised that this area has public access, therefore the door is locked when individuals and/or staff are not present to prevent intruders accessing this area.

We were advised that individuals who are not restricted to the ward can request staff to open the door and access the garden and that individuals would be informed of this.

One person we met with told us they felt concerned by the number of individuals smoking in the garden areas attached to the ward. We also observed someone smoking in their bedroom on the day of our visit, which was passed to SCN for action.

The Commission is clear that smoking on hospital grounds is an offence, with individuals being at risk of penalty notices and fines. While the Commission understands that individuals may experience difficulties in relation to nicotine withdrawal, we are aware that other acute adult admission services are effectively managing smoking bans and utilising nicotine replacement and support services.

We would encourage NHS GG&C managers to ensure staff have clear guidance regarding implementation of the smoking ban. The Commission will continue to escalate these concerns with NHS GGC managers.

Recommendation 9:
Managers for McNair Ward should ensure that legislation and local procedures are adhered to in relation hospitals buildings being smoke free.

Summary of recommendations

Recommendation 1:
Managers responsible for McNair Ward should carry out an audit of person-centred care plans to ensure they are individualised with meaningful interventions clearly recorded.

Recommendation 2:
Managers responsible for McNair Ward should audit risk assessment documentation to ensure they are reviewed, with information provided on how each risk should be managed.

Recommendation 3:
Managers responsible for McNair Ward should audit all care records to ensure individuals and their families are being appropriately consulted with their views clearly recorded

Recommendation 4:
Managers in McNair ward should audit MDT records to ensure discussions and agreed actions which relate to individualised care goals are consistently recorded and acted upon.

Recommendation 5:
Medical staff on McNair Ward should ensure that all prescribed medication is appropriately authorised under the Mental Health Act.

Recommendation 6:
Managers responsible for McNair Ward should ensure copies of guardianship orders, or power of attorney documents are available in individual care records.

Recommendation 7:
Medical staff should ensure that, where a treatment plan is required, it is completed for all patients

Recommendation 8:
When someone is made a specified person, medical staff responsible for McNair Ward should provide individuals with written information regarding restrictions in place, timescales for review and information about their rights.

Recommendation 9:
Managers for McNair Ward should ensure that legislation and local procedures are adhered to in relation hospitals buildings being smoke free.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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